United Nations A/69/916

General Assembly

Distr.: General
27 May 2015

Original: English

Sixty-ninth session
Agenda item 12
2001-2010: Decade to Roll Back Malaria in Developing Countries, Particularly in Africa

Implementation of General Assembly resolution 68/308 on consolidating gains and accelerating efforts to control and eliminate malaria in developing countries, particularly in Africa, by 2015

Note by the Secretary-General

The Secretary-General has the honour to transmit to the General Assembly the report of the Director-General of the World Health Organization, submitted in accordance with General Assembly resolution 68/308.

15-08326 (E) 100615

Please recycle

Report of the Director-General of the World Health Organization

Summary

The present report is submitted in response to General Assembly resolution 68/308. It provides a review of progress in the implementation of that resolution, focusing on the adoption and scaling up of interventions recommended by the World Health Organization in malaria-endemic countries. It provides an assessment of progress towards the 2015 global malaria targets, including Millennium Development Goal 6, targets set through the African Union and the World Health Assembly and goals set through the Global Malaria Action Plan developed by the Roll Back Malaria Partnership. It elaborates on the challenges limiting the full achievement of the targets and provides recommendations to ensure that progress is accelerated in the coming years.

I. Introduction

1. While malaria is a preventable and treatable disease, it continues to have a devastating impact on people's health and livelihoods around the world. In 2013, some 3.3 billion people were at risk of the disease in 97 countries and territories, and an estimated 198 million malaria cases occurred (uncertainty range: 124 million-283 million). The disease killed 584,000 people (uncertainty range: 367,000-755,000), mostly children under 5 years of age in sub-Saharan Africa. The World Health Organization (WHO) recommends a multi-pronged strategy to reduce the malaria burden, including vector control interventions, preventive therapies, diagnostic testing, quality-assured treatment and strong malaria surveillance.

2. The present report highlights progress and challenges in the control and elimination of malaria in the context of General Assembly resolution 68/308. It draws on the WHO *World Malaria Report 2014* and on contributions received from the Roll Back Malaria Partnership secretariat, the African Leaders Malaria Alliance and the United Nations Children's Fund (UNICEF). The analysis is based on the latest available comprehensive data (2013) received from malaria-endemic countries and organizations supporting global malaria efforts. Data from 2014 are currently being collected and reviewed by WHO. Those, together with projections for 2015, will be published in the *Millennium Development Goals Report 2015*.

3. Over the past 10 years, malaria has received worldwide recognition as a priority global health issue. Under the umbrella of the Roll Back Malaria Partnership, endemic countries, United Nations agencies, bilateral donors, public-private partnerships, scientific organizations, academic institutions, non-governmental organizations and the private sector have been working together to scale up interventions recommended by WHO, harmonize activities and improve strategic planning, programme management and the availability of funding. A steep rise in international funding has enabled endemic countries to expand their malaria programmes. Since 2010, the Global Fund to Fight AIDS, Tuberculosis and Malaria has provided more than $3 billion for malaria interventions, while the Governments of the United States of America and the United Kingdom of Great Britain and Northern Ireland have been the second and third largest bilateral funders.

4. The success of efforts to control and eliminate malaria is measured by an analysis of trends in the disease burden and intervention scale-up and a review of progress made towards a set of global goals and targets that have been designed through intergovernmental processes or set in the context of global initiatives. The four main sets of goals and targets are Millennium Development Goal 6, targets set through the African Union and the World Health Assembly and goals set through the Global Malaria Action Plan developed by the Roll Back Malaria Partnership. Further details are provided in section IV. Regional and subregional targets for malaria control and elimination are not addressed herein.

II. Current situation

5. Between 2000 and 2013, an expansion of malaria interventions helped to reduce malaria mortality rates by 47 per cent worldwide, averting an estimated 4.3 million deaths. The malaria mortality rate in the under-5 age group in Africa declined by 54 per cent during that period. Global case incidence was reduced by

30 per cent. A new analysis, published in 2014, reveals that the number of people who carried the malaria parasite in sub-Saharan Africa (i.e., both symptomatic and asymptomatic malaria infections) was reduced from an estimated 173 million in 2000 to 128 million in 2013, notwithstanding an increase of 43 per cent in population levels in malaria-endemic countries of Africa.

6. Overall, the world is on track to achieve the Millennium Development Goals target for malaria: between 2000 and 2013, the rise of malaria incidence was halted and reversed around the world. However, the disease remains concentrated in 16 countries where about 80 per cent of global malaria deaths occur. Africa bears the world's highest malaria burden, with two countries — the Democratic Republic of the Congo and Nigeria — accounting for about 39 per cent of malaria mortality worldwide. In South-East Asia, the second most affected part of the world, India has the highest malaria burden. Overall, progress in reducing the malaria burden has been swifter in countries that had lower rates of transmission in 2000.

Vector control measures

7. The scaling-up of insecticide-treated bednet distribution[1] and indoor residual spraying programmes has been a critical factor in bringing down disease transmission. Between 2004 and 2014, more than 900 million insecticide-treated bednets were delivered to countries in Africa, leading to a major increase in household ownership and bednet use. An estimated 49 per cent of the population at risk of malaria had access to a bednet in their household in 2013, compared with only 3 per cent in 2004. Meanwhile, the proportion of the at-risk population sleeping under an insecticide-treated bednet (representing the population directly protected) was 44 per cent in 2013.

8. That progress notwithstanding, only a few countries have managed to scale up access to insecticide-treated bednets to very high levels and major disparities remain between countries and across regions. The primary reason has been a shortage of financial resources to procure and distribute sufficient bednets to cover all affected communities. It is encouraging, however, that, in all countries surveyed, insecticide-treated bednet use was higher in the two most vulnerable groups — children under 5 years of age and pregnant women — than national averages.

9. In more than 60 countries, national malaria control programmes also include regular indoor spraying of homes to reduce the mosquito population that can carry the disease. In 2013, 124 million people were protected through that intervention. The proportion of the population protected by indoor spraying in Africa increased substantially during the period 2006-2008 and reached 11 per cent of the population at risk in 2010. By 2013, however, that proportion had fallen to 7 per cent owing to a contraction of spraying programmes in some countries as a result of the high cost of the insecticides that need to be used to prevent or manage mosquito resistance.

10. While current vector control tools remain effective, there is an urgent need to manage increasing mosquito resistance to insecticides in all endemic countries and to develop new formulations of insecticides and new tools. Since 2010, insecticide resistance has been reported by 53 countries, including most endemic countries in

[1] Although WHO recommends the use of long-lasting insecticidal nets, given the continued use of conventional insecticide-treated nets, especially outside Africa, the more generic term "insecticide-treated nets" is used throughout the present report.

Africa. In 2012, WHO and the Roll Back Malaria Partnership released the Global Plan for Insecticide Resistance Management in Malaria Vectors, which provides tailored guidance to countries, partners and the private sector. Most malaria-endemic countries are now undertaking insecticide resistance monitoring, but few have drawn up detailed plans to manage resistance.

Diagnostic testing and treatment

11. Artemisinin-based combination therapies are currently the most effective medicines for uncomplicated malaria caused by the *Plasmodium falciparum* parasite (the most lethal parasite, responsible for the large majority of malaria cases in Africa). Over the past eight years, the increasing availability of quality-assured combination therapies has helped to improve malaria treatment rates and reduce the number of severe cases and deaths. Between 2009 and 2013, the number of combination treatment courses distributed by national malaria programmes to public sector health facilities in Africa doubled (from 98 million to 181 million treatment courses), progressively replacing other, less-effective antimalarial treatments. In April 2015, WHO released a new edition of its malaria treatment guidelines, which included updated guidance on appropriate weight-based dosing of antimalarials.

12. WHO recommends diagnostic testing of all suspected malaria cases when patients seek treatment at health clinics, pharmacies or with community health workers. Rapid diagnostic tests are now widely available and more than 319 million were purchased in 2013, compared with 46 million in 2008. This has occurred in parallel with a gradual improvement in the quality of rapid diagnostic tests, as demonstrated by the WHO Malaria Rapid Diagnostic Test Product Testing Programme, managed jointly by WHO, the United States Centers for Disease Control and Prevention, the Foundation for Innovative New Diagnostics and the Special Programme for Research and Training in Tropical Diseases.

13. The significant expansion of malaria diagnostic testing and treatment in recent years notwithstanding, millions of people continue to lack access to those services. Some 80 per cent of all children under 5 years of age with malaria (an estimated 56 million-69 million children) receive no artemisinin-based combination therapy at all. Similar coverage gaps have been seen in relation to preventive treatments, which are recommended for the most vulnerable groups in sub-Saharan Africa: pregnant women, children under 5 years of age and infants. Such treatments are highly cost-effective and have the potential to save tens of thousands of lives each year. The urgent need to fill those gaps was reinforced on World Malaria Day 2015, when Roll Back Malaria partners, including WHO and UNICEF, called upon the global health community to help to increase national coverage rates. The Roll Back Malaria Partnership also issued a global call to action to prevent the devastating outcomes associated with malaria during pregnancy.

14. Community-based health programmes can significantly reduce malaria-related child mortality in rural communities and the approach is being scaled up around the world. The Government of India, for example, has deployed more than 900,000 accredited social health activists nationwide in the past 10 years. They provide a basic package of curative care to all age groups, make timely referrals and promote immunization and other public health services. In Africa, WHO and UNICEF have helped countries to expand efforts to scale up integrated community case management programmes, through which community health workers are trained to

diagnose and treat children under 5 years of age for malaria, pneumonia and diarrhoea. Through a programme funded by the Government of Canada and supported by WHO and non-governmental organizations, more than 7,000 community health workers were trained and deployed in five African countries between 2012 and 2014, treating in excess of 650,000 children.

15. The Ebola virus disease outbreak in Guinea, Liberia and Sierra Leone in 2014/15 severely compromised those countries' health systems. To manage and reduce the malaria burden, WHO issued guidance on the prevention, diagnosis and treatment of malaria in Ebola-affected areas, including recommending the use of mass drug administration in Ebola hotspots to reduce the number of malaria cases. With support from UNICEF, the Global Fund and other partners, the Government of Sierra Leone carried out two rounds of mass drug administration, covering more than 2.6 million people between December 2014 and January 2015. The Government of Liberia reached more than 300,000 people with its mass drug administration campaign in the capital, Monrovia. WHO and partners are now helping affected countries to rehabilitate health-care services, scale up malaria interventions, address the shortages of diagnostic tests and drugs and strengthen malaria surveillance.

Increasing drug resistance

16. Over the past year, the extent of artemisinin resistance and multi-drug resistance (including resistance to artemisinin-based combination therapies) has significantly worsened in the Greater Mekong subregion of South-East Asia. Unless the issue is addressed urgently, drug-resistant malaria could become a major global public health threat, weakening the tools currently used to combat the disease. Following the launch of the emergency response to artemisinin resistance in the Greater Mekong subregion in 2013, WHO set up a biregional programme in Phnom Penh to coordinate the multi-stakeholder response. The hub works closely with ministries of health in Cambodia, China, the Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam, as well as a range of development partners.

17. To tackle emerging multi-drug resistance, WHO has recommended an urgent scaling-up of malaria prevention measures throughout the subregion and a recalibration of efforts from resistance containment to regional malaria elimination by 2030. This follows the conclusion adopted by the WHO Malaria Policy Advisory Committee in September 2014 that the elimination of *Plasmodium falciparum* was feasible by 2030 and should be initiated as soon as possible. WHO is currently developing a subregional strategy that will help affected countries to reorient programmes to target malaria elimination. In developing the strategy, WHO has coordinated closely with countries and development partners and the draft document has been reviewed by the Committee.

18. The continued availability and use of oral artemisinin-based monotherapies poses a major risk to malaria control efforts globally and has contributed to the emergence of artemisinin resistance. WHO has long recommended the withdrawal of oral artemisinin-based monotherapies from the market and their replacement with combination therapies, as endorsed by the World Health Assembly in 2007. According to the latest available information, however, those medicines continue to be marketed by at least 25 companies worldwide. Globally, 48 countries have withdrawn marketing authorization, but 8 continue to allow them to be marketed.

Malaria surveillance

19. While malaria case detection rates are gradually improving, only every seventh case is captured by surveillance systems globally. In 41 endemic countries, it is impossible to reliably assess malaria trends owing to incompleteness or inconsistency of reporting over time, or changes in diagnostic practice or health service utilization. There is a critical need to strengthen malaria surveillance systems to enable ministries of health to identify gaps in programme coverage and to respond to disease outbreaks effectively. Strong surveillance also helps to guide changes in programme planning and implementation so that resources can be directed to populations most in need and can help to assess the impact of interventions.

20. Strengthening surveillance systems is one of the three main pillars of the new WHO global technical strategy for malaria (2016-2030), which was endorsed by the World Health Assembly in May 2015. In the new strategy, countries are urged to substantially expand malaria surveillance and transform it into a core intervention as important as vector control, diagnostic testing or treatment. In addition to helping to accelerate progress towards the proposed targets, increased investment in malaria surveillance will ease the current reliance on model-based disease estimation methods and enable national decision makers and the global health community to build on more reliable health information and malaria data.

21. The strengthening of malaria surveillance has also been an important pillar of the WHO "T3: Test. Treat. Track" initiative, which was launched by the Director-General in April 2012 in Namibia. As part of the initiative, WHO encourages malaria-endemic countries and global malaria partners to scale up diagnostic testing, quality-assured treatment and surveillance to amplify the impact of prevention measures and further accelerate progress. The initiative was built on four core malaria guidance documents: the operational manuals entitled *Universal Access to Malaria Diagnostic Testing, Disease Surveillance for Malaria Control and Disease Surveillance for Malaria Elimination and the Guidelines for the Treatment of Malaria.*

Elimination and certification

22. In total, 26 endemic countries are close to eliminating malaria and their malaria programmes are currently in the pre-elimination, elimination or prevention of reintroduction phase. Many more countries have declared malaria elimination a national goal. In recent years, elimination efforts have been intensified in many parts of Africa, including the Southern African "Elimination 8" countries (Angola, Botswana, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe), in Central America and Hispaniola and in South-East Asia. In recent years, four countries have been certified by WHO as free of malaria: United Arab Emirates (2007), Morocco (2010), Turkmenistan (2010) and Armenia (2011). The certification process for Kyrgyzstan is continuing and WHO will soon begin the process for Argentina.

23. In many countries nearing elimination, malaria transmission occurs mostly in areas with limited transport and public health infrastructure, often near international borders. A high proportion of malaria cases are seen among migrant and mobile populations In those countries, progress towards elimination will require improved commodity delivery strategies and an expansion of access to health services for

affected groups. Strong regional and cross-border collaboration and improvements in diagnostic tools are also essential for sustaining progress.

New global guidance from the World Health Organization

24. In 2013, WHO began developing a new global malaria strategy to provide countries with evidence-based technical guidance for the period 2016-2030. The draft strategy was finalized in October 2014 and reviewed by the WHO Executive Board in January 2015. The document was developed in close consultation with endemic countries and partners and the process was overseen by the Malaria Policy Advisory Committee and a dedicated steering committee. The World Health Assembly adopted the document in May 2015 by its resolution WHA68.2.

25. The strategy sets the target of reducing the malaria disease burden by at least 40 per cent by 2020 and by at least 90 per cent by 2030. It also aims to eliminate the disease in at least 35 new countries by 2030. The document is built on the following three pillars: ensuring universal access to malaria prevention, diagnosis and treatment; accelerating efforts towards elimination and attainment of malaria-free status; and transforming malaria surveillance into a core intervention. The pillars are complemented by two supporting elements: harnessing innovation and expanding research; and strengthening the enabling environment. The strategy emphasizes that progression towards malaria-free status does not consist of a set of independent phases; instead, it is a continuous process requiring subnational stratification by malaria risk.

26. The strategy provides the technical underpinning for the second edition of the Roll Back Malaria Partnership's Global Malaria Action Plan, "Action and investment to defeat malaria 2016-2030", which is scheduled to be released in July 2015. The plan will focus on how the WHO strategy can best be implemented though global advocacy, resource mobilization, partner harmonization and the engagement of the transportation, industry, tourism, education and other public sectors, as well as the private sector. It positions malaria firmly in the post-2015 development agenda, showing how progress towards multiple sustainable development goals will be contingent on the success of malaria efforts. Joint regional consultations and separate public web consultations were held on the two documents between February and August 2014.

27. Since the previous progress report (A/68/854), WHO has issued updated guidelines on the treatment of malaria and guidance documents on temporary malaria control measures in Ebola-affected countries, recommended selection criteria for the procurement of malaria rapid diagnostic tests and the control of residual malaria parasite transmission. WHO has also developed a malaria elimination strategy for the Greater Mekong subregion and published elimination case studies (Bhutan, the island of Reunion, Malaysia and the Philippines) together with the Global Health Group at the University of California, San Francisco. In addition, the report of each meeting of the Malaria Policy Advisory Committee, the independent expert group that advises WHO on new malaria policies, has been published in the open-access *Malaria Journal*.

Regional collaboration and political commitment

28. In the Asia-Pacific region, recent years have witnessed growing political commitment to addressing the challenge of drug-resistant malaria. Countries of the

region, with leadership from Australia and Viet Nam, launched the Asia Pacific Leaders Malaria Alliance at the East Asia Summit held in Brunei Darussalam in October 2013. In November 2014, 18 heads of State at the East Asia Summit made a commitment to eliminating the disease from the Asia-Pacific region by 2030. WHO welcomed the initiative and has been supporting the Asia Pacific Leaders Malaria Alliance secretariat, based at the Asian Development Bank in Manila, with technical advice.

29. African Heads of State and Government continued to meet twice a year for a dedicated malaria forum at the African Union Summit to reaffirm their commitment to efforts to combat malaria. In 2015, 49 member States are working together under the auspices of the African Leaders Malaria Alliance. At the most recent forum, held in January 2015, leaders launched a 2030 scorecard towards malaria elimination and 12 countries received an award for excellence from the Alliance for expanding or sustaining malaria interventions. The Prime Minister of Ethiopia has chaired the Alliance since June 2014. In April 2015, African Union ministers of health reiterated their commitment to accelerating efforts to eradicate HIV/AIDS, tuberculosis and malaria and agreed to develop a road map detailing key milestones that should be achieved by 2030.

30. The "A promise renewed" initiative has been endorsed by 178 Governments since its adoption at the Child Survival: Call to Action high-level forum, held in Washington, D.C., in June 2012. The initiative has triggered new commitments to protecting the most vulnerable communities in many malaria-endemic countries. The importance of expanding efforts to combat malaria and, in particular, the urgent need to tackle drug-resistant malaria have also been central to government efforts under the Global Health Security Agenda. Launched in February 2014 and adopted by more than 40 countries, the Agenda is an effort to reduce infectious disease threats and to promote global health security as an international security priority.

III. Urgent funding needs

31. While international disbursements for malaria have increased substantially since 2005, available funding remains well below the $5.1 billion needed to achieve universal coverage of malaria interventions in all endemic countries. International financing for malaria exceeded $2.1 billion in 2013, while national financing was estimated to be $527 million. The combined resources available for malaria efforts globally were estimated to be just in excess of $2.7 billion in 2013.

32. According to the WHO global strategy, the required funding for malaria investments will increase to an estimated $6.5 billion per year by 2020. This can be achieved only if international and national funding increase markedly in the coming five years. Throughout 2014, Roll Back Malaria partners, including WHO, provided technical support to endemic countries to develop malaria concept notes for the Global Fund. The estimated value of the financial support requested therein is $2.8 billion.

IV. Progress towards global goals and targets

33. The success of efforts to control and eliminate malaria is measured by progress made towards a set of targets for 2015 that have been designed through intergovernmental processes or set in the context of global initiatives. Progress is summarized each year by WHO in the *World Malaria Report*, which provides a comprehensive overview of trends in programme financing, intervention coverage and malaria cases and deaths. Data are received from national malaria control programmes in endemic countries, through WHO regional offices, and are complemented by information received through household surveys, notably demographic and health surveys, multiple indicator cluster surveys and malaria indicator surveys.

34. Assessing country progress towards global targets has been challenging in many high-burden countries in Africa, given that only a fraction of malaria cases and deaths are captured by disease surveillance systems. In 41 malaria-endemic countries, 32 of which are in Africa, an assessment of malaria trends can be made only using burden estimation methods that rely on a modelled relationship between malaria transmission, intervention coverage and case incidence or mortality.

Millennium Development Goal 6

35. Together with HIV/AIDS and other diseases, malaria control has been covered by Millennium Development Goal 6. The malaria-specific target has been to "have halted by 2015 and begun to reverse the incidence of malaria". Given that malaria accounts for 7 per cent of under-5 mortality globally, it has also been central to making progress towards Goal 4, target 4.A, "to reduce by two thirds, between 1990 and 2015, the under-5 mortality rate". Global malaria efforts are also making a contribution to Goals 1, 2, 3, 5 and 8.

36. An assessment of global malaria trends between 2000 and 2013 indicates that the world is on track to achieve Goal 6, target 6.C. Between 2000 and 2013, malaria incidence rates — which take into account population growth — were reduced by 30 per cent globally and by 34 per cent in Africa. The malaria mortality rate decreased by 47 per cent worldwide during the same period and the decline in Africa was 54 per cent. On the basis of the data reported, 64 countries are on track to reverse malaria incidence and are therefore meeting Goal 6.

37. It is estimated that, had the malaria trends of the 1990s not been reversed, 670 million more malaria cases and 4.3 million more malaria deaths would have occurred between 2001 and 2013. A total of 3.9 million of those deaths would have occurred among children under 5 years of age in Africa; the number of deaths averted accounted for a reduction of 20 per cent in overall child mortality during that period. Most of the malaria cases averted (66 per cent) and lives saved (92 per cent) were in Africa. Progress is likely to be related to a combination of expanded malaria interventions, increased urbanization and overall economic development.

Abuja targets

38. By adopting the Abuja Declaration on Roll Back Malaria in Africa and its plan of action at the Extraordinary Summit of African Heads of State and Government, held in Abuja in April 2000, leaders of malaria-endemic countries in Africa committed themselves to halving malaria mortality by 2010. The target was later

extended to 2015. The Abuja Declaration also contained a commitment to reducing or waiving taxes and tariffs on imported antimalarial medicines, insecticide-treated nets and other essential malaria commodities. In 2006, the Declaration was complemented by the Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services in Africa.

39. Information on country progress in reducing malaria mortality will be made available by WHO later in the year. For now, progress towards the Abuja targets can be measured only through an analysis of trends in malaria incidence. In 2014, 12 countries in the WHO African region were on track to reduce malaria incidence by more than 50 per cent by 2015. Nine (Algeria, Botswana, Cabo Verde, Eritrea, Namibia, Rwanda, Sao Tome and Principe, South Africa and Swaziland) have already reduced their case incidence by more than 75 per cent. Ethiopia, Zambia and Zimbabwe are projected to reach the target by 2015. In other African countries, it has not been possible to reliably assess malaria trends owing to incompleteness or inconsistency in reporting.

World Health Assembly targets

40. In 2005, the World Health Assembly set the target of reducing the malaria burden by 50 per cent between 2000 and 2010 and by 75 per cent by 2015. According to the *World Malaria Report 2014*, 58 of the 106 countries and territories with ongoing malaria transmission in 2000 were on track to achieve a reduction of 75 per cent in malaria mortality by 2015. Globally, malaria mortality was reduced by 47 per cent between 2000 and 2013, while the decline in Africa was 54 per cent. To achieve swifter progress towards the target, efforts need to be substantially expanded in the 16 countries with the highest burden, which account for an estimated 80 per cent of deaths from malaria.

Global Malaria Action Plan goals

41. The Roll Back Malaria Partnership's Global Malaria Action Plan was launched in 2008 to catalyse support for malaria control and elimination and to rally partners around a common plan of action. The objectives of the Action Plan, as revised in 2011, were to reduce global malaria deaths to "near zero" by the end of 2015, to reduce global malaria cases by 75 per cent by the end of 2015 and to eliminate malaria by 2015 in at least 8 to 10 new countries and in the WHO European region. The Partnership called for an estimated $5.1 billion annually to ensure universal coverage of malaria interventions. Those funding targets could not be fully achieved, however, partly because of decreases in global health and development funding triggered by the global financial crisis.

42. As the figures cited above show, there has been steady progress towards all those ambitious goals. To move closer to attaining the first two goals of the Action Plan, an urgent and significant expansion of financing would be required, in particular in the highest-burden countries. Meanwhile, the third goal has already been met: 10 new countries (within and outside the European region) have reduced local malaria transmission to zero since 2008 (Argentina, Azerbaijan, Egypt, Georgia, Iraq, Kyrgyzstan, the Russian Federation, Sri Lanka, the Syrian Arab Republic and Uzbekistan). Three others have been certified by WHO as free of malaria since 2008 (Armenia, Morocco and Turkmenistan). With local transmission

confined to two countries in the European region in 2013 (Tajikistan and Turkey), that region is on track to reduce local malaria cases to zero by 2015.

V. Recommendations

43. **A concerted and coordinated global effort will be needed to substantially reduce malaria transmission, morbidity and mortality by 2030 and achieve the targets set by the new WHO global technical strategy for malaria (2016-2030). Progress can be accelerated through a multi-pronged response that is aimed at a major expansion of currently available life-saving interventions by making malaria a higher political priority, by increasing accountability, by strengthening regional and cross-border collaboration and by ensuring that the development and use of new tools and approaches are maximized.**

44. **The expansion of malaria interventions can be used as an entry point for strengthening health systems, including maternal and child health services and laboratory services, and to build stronger health information and disease surveillance systems. A further scaling-up of integrated community case management in the highest-burden countries and a strengthening of integrated delivery systems for malaria prevention tools would be a cost-effective solution to help to bridge systems gaps until health infrastructure is further strengthened.**

45. **There is an urgent need to increase the availability of financing for efforts to combat malaria through both traditional and innovative financing tools to alleviate the suffering caused by the disease. Only through substantial scaling-up and sustaining of coverage can countries prevent malaria resurgences and move towards the ambitious 2030 malaria targets. Adequate and predictable financing is also essential for recent successes to be protected. Were countries to fall back to existing levels of intervention coverage, much of the gains and investments dedicated to this cause could be swiftly erased.**

46. **Endemic countries are urged to increase the national resources that they make available to combat the disease. It is also recommended that they review and strengthen national strategic plans in line with WHO technical recommendations and embed them firmly in national health sector and development plans. To achieve better impact and ensure that successes are sustained, countries should increasingly adopt a multisectoral approach to combating the disease and build on synergies with other development priorities.**

47. **Global development partners and endemic countries should strengthen efforts to tackle emerging biological threats to malaria control. Parasite resistance to artemisinin can be prevented through the implementation of the WHO recommendations contained in the Global Plan for Artemisinin Resistance Containment. Strong political commitment is required to launch a coordinated and renewed effort to phase out the use of oral artemisinin-based monotherapies and to remove from markets antimalarial medicines that do not meet WHO prequalification standards. The emergence of insecticide resistance can be controlled through the adoption of recommendations contained in the Global Plan for Insecticide Resistance Management in Malaria Vectors.**

48. **There is a critical need to strengthen malaria surveillance and data quality in all endemic regions to enable ministries of health to direct financial resources to populations most in need and to respond effectively to disease outbreaks. Given the plethora of partners on the ground, mechanisms for country-based coordination of technical assistance should be strengthened to achieve alignment of the best approaches to implement WHO technical guidance. Additional financing is needed to support the sharing and analysis of best practices to address urgent programmatic challenges, to improve monitoring and evaluation and to conduct regular financial planning and gap analysis.**

49. **The contributions of the scientific community and the private sector remain essential. New products such as improved diagnostic tools, more effective medicines, new insecticides and more durable insecticide-treated bednets are all fundamental to ensuring sustained progress in efforts to combat the disease. The remarkable progress achieved can be maintained only through a concerted and focused multi-stakeholder effort, built on the foundation of global political commitment, continuous scientific advancement and vigorous innovation. An effective global partnership under the umbrella of the Roll Back Malaria Partnership will continue to be fundamental beyond 2015.**